The roots of the pride I still feel when I tell people that I work in the NHS can be traced precisely to two events that happened within a fortnight of each other 70 years ago.

Arguably the most important social change in the history of the UK occurred on 5 July, 1948, when health secretary Aneurin Bevan visited Park Hospital in Manchester to launch his hugely ambitious “brain child” – the National Health Service.

In these cash-starved times, when there is still so much more to do as set out in an overview and look at the future of research by Anne Lingford-Hughes (Page 15), professor of infectious disease epidemiology at UCL and chair of the Academy of Medical Sciences “Health of the Public 2040” working group, the pressures on young people are very different from what they were back in 1948. Why are so many more now reporting mental health problems, and why are so many self-harming? Resources are urgently needed for research into the underlying causes (Page 15).

There are demands for parity of esteem for mental health, and rightly so, but this must extend to research as well. They are fundamental to improving healthcare, and it is a marker of a quality service when patients are involved in research. They are over-represented in research as it is treated as a “Cinderella science”. And there are powerful arguments about the power of research, consultant occupational therapist Suzie Willis (Page 18) gives a moving account of how clinical trials led by inspirational oncologist Dr David Chao at the Royal Free Hospital, Hampstead, helped to save the life of her husband.

In an era of unprecedented pressures on the NHS, exacerbated by a rapidly ageing population, Bob Howard (Page 8), UCL professor of old age psychiatry, welcomes the gradual destigmatising of dementia. However, he sounds a warning that strained resources are affecting quality of care.

Professor Helen Killaspy (Page 10), consultant psychiatrist for the Islington community rehabilitation team, outlines a pathway to help people with complex psychosis to live successfully in the community – but fears that long-term hospitalisation is trapping people in private sector “virtual asylums”. One area that has changed beyond all recognition over the last 70 years is in the attitudes and approaches to improving sexual health. Claudia Escourt (Page 12), clinical professor of sexual health and HIV, also airs concerns about lack of funding and how it undermines the improvements in attitudes. The pressures on young people are very different from what they were back in 1948.

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Appliance of alliances can create a healthier future

Dame Anne Johnson, professor of infectious disease epidemiology at UCL and chair of the Academy of Medical Sciences, working group on the health of the public in 2040, sets out the crucial links between research and healthcare.

The way we practise medicine has undoubtedly been revolutionised by research initiatives such as the international Cochrane Collaboration, established in 1993 to conduct systematic reviews and guide clinical practice—一起 with much−improved, evidence−based trials—for medicines and other preventive interventions. The National Institute for Health Research (NIHR), which looks at how we can invest money in the NHS for research in a more focused and high−quality way.

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Developing transdisciplinary research capacity and optimising the research environment for a healthier, fairer future were key aims of the Revolutionaries in Medicine (NICE) working group that I chaired, and which produced the 2016 report Improving the Health of the Public by 2040.

One of the major developments of the last few decades has been HIV treatment. When I came into medicine in the late 1970s, there was no HIV epidemic in human populations. The first cases of AIDS were described in the 1980s, and I had the job in 1987 of helping design the first Aids ward in London, at the Middlesex Hospital. At that time, the young men admitted to the ward died on average within six months of diagnosis. So it is extraordinary that we moved from what was a frightening, untreatable disease with an unknown cause to identifying the virus and within little more than a decade, having effective antiretroviral treatments that are now rolled out worldwide.

The AIDS epidemic also had important social consequences. To some extent, the gay community forced a dialogue between patients and professionals that enabled people to be engaged in a more egalitarian relationship about how we negotiate the management of disease. Unfortunately we haven’t been able to stop the epidemic or develop a vaccine, which was the great hope of the 1980s. The issues around HIV have helped reduce stigma about the way we view sex and sexuality.

Over my career, there has been a great deal of stigma about the way we view sex and sexuality. The issues around HIV have helped reduce stigma about the way we view sex and sexuality. Over my career, there has been a great deal of investment in sexual health strategy and services. But, very regretfully, there is now a crisis in these services due to disinvestment since they were moved outside the NHS into local authorities. It has been a serious step backwards.

The approach to mental health has become much more enhanced over the years. When I was training in medicine, 30 years ago, there were still large Victorian asylums with massive inpatient facilities where people could be kept for years, even for their lifetime.

We now have more treatments at our fingertips, and development of cognitive behavioural therapy (CBT) and community services have been very important, but there are real concerns about the quality of mental health services.

The chief medical officer and others emphasise the importance of mental health, but there are real concerns about the quality of mental health services. The chief medical officer and others emphasise the importance of mental health, but there are real concerns about the quality of mental health services.

Extraordinary advances in our understanding of the genetics of cancer have meant we are able to use more personalised treatments, including immunotherapies, which may be much less toxic than some less specific cancer treatments that still have terrible side−effects.

The remaining challenge for cancer within the NHS is early detection. Screening programmes mean we are better at detecting breast, bowel and cervix cancer while we have expecting big reductions in cervical cancer rates due to the development of the human papilloma virus (HPV) vaccine.

- Dame Anne Johnson

NHS 10: “We can use our NHS resources effectively if we integrate preventive and public health interventions” – Dame Anne Johnson

Mortality from cardiovascular disease has been reduced and we have made enormous strides in the quality of cancer therapy, and chemotherapies in particular — although the UK is still behind some other European countries in cancer survival and detection.

The NHS has a part to play, but so do factors such as social services, social interventions, good pensions, good diet, exercise programmes, work for older people who want to go on working, and all those other professions allied to medicine and social care that are an important part of a strategy for the elderly.

We are also seeing increasing rates of obesity, diabetes, and mental health. We are seeing increasing rates of obesity, diabetes, and mental health. We are also seeing increasing rates of obesity, diabetes, and mental health.
The origins of the epidemic lie with social inequalities, how food is sold and manufactured, exercises, built environment and transport. We need a fundamental change in research programmes that recognise the multi-system nature of many health problems, which we can’t tackle without considering the socioeconomic environment.

We are in the midst of a digital and information revolution that is equivalent to the industrial revolution – and it is vital that the NHS adapts. Eric Topol, who wrote a book called The Patient 2.0, is the “father” of means.”

Eric Topol, who wrote a book called The Patient 2.0, is the “father” of this revolution – and it is vital that the NHS adapts. Thanks to the web, people can be more civilised if a sick person is denied medical aid in young children, and that’s going to lead to suchOur patients due to lack of communication. Knowing how much time and energy on repeat investigations or failing to remote consultation; we wouldn’t waste so much integrated, accessible patient records and more Genomics, aligned with good patient data, allows us to put together what we know about the genes with how they’re manifested in the way diseases are being conducted remotely, on Skype and mobiles. We’re developing diagnostics that can be used remotely for infectious diseases, but, if we’re going to reap the benefits, a huge investment is needed to get the workforce and technology up to speed.

For many, the digital revolution has the potential to transform the way we practise medicine.

In theory, this allows us to put together what we know about the genes with how they’re manifested in illnesses they cause. But, if we are going to reap the benefits, a huge investment is needed to get the workforce and technology up to speed. Some factors can be reduced by medical interventions to increase modifiable risks. If somebody’s got high blood pressure, high cholesterol, is overweight, they can do something about it. And we must take into account what I call the “triple burden” of disease, which we can’t tackle without considering the social and environmental aspects.

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Burden of fighting to overcome an age-old enemy

Rob Howard, professor of old age psychiatry at UCL and honorary consultant with Camden and Islington NHS Trust, explains how increasingly strained resources are affecting the quality of dementia care.

Seventy years ago, dementia was a stigmatised and shameful diagnosis. It would have been referred to as senile decay, and feared in the same way as schizophrenia or major mood disorders. You kept very quiet if someone in your family had dementia.

When I first became a psychiatrist, in the late 1980s, I'd occasionally have to go to see a patient in one of the old asylums that were still open around London. Some were like mini-cities with thousands of patients – most of whom had spent their entire adult lives in hospital.

There were also large numbers of people with dementia who were looked after on long-stay psychogeriatric wards.

What they had in common was that the patients certainly didn't get personalised care, and I can remember as a young doctor being frightened by the horror of this.

Although dementia care is far from perfect nowadays, the most important development is that people are supported to go on living in their own homes.

However, this means that families are carrying what can be a heavy burden of care, and they are often understandably bitter about the quality and quantity of support they receive from local authorities and the NHS.

Local authorities' social services budgets have suffered over the last 10 years and, unfortunately, services for older people have taken an unfair burden on the health system.

One big positive is that the stigma of dementia is being addressed. There is now much more open conversation about it compared even with 10 years ago.

We are also now recognising and diagnosing about 75% of people with dementia, and that's a huge achievement. Unfortunately, although we have drug treatments that make very modest improvements in the symptoms of dementia, we still have nothing that can affect the course and decline.

The government and charities – the Alzheimer's Society and Alzheimer Research UK – have made major financial investment in a national Dementia Research Institute, based at UCL, to accelerate the development of new treatments.

Because we're better at recognising it, there's a chance that the quality of care of people who've got dementia along with other conditions.

For example, if you have unrecognised dementia and you suffer a heart attack and go into hospital, you are likely to have a difficult time because no one will appreciate your need to have things explained or why you may appear uncooperative.

Hospitals and community services have become much more dementia-friendly places, and research by my UCL colleague Gill Livingston has developed simple interventions to reduce distress and depression in people who care for family members with dementia.

The great disappointment from the 30 years that I've been working in this field has been the failure of treatments to stop or slow the progression of dementia. More than 200 different drugs have been tested, and all have failed.

The frontrunners at the moment are those that raise [induce the production of] antibodies against the amyloid protein that is linked to Alzheimer's disease. A drug called BAN2410 is the most likely to appear on the treatment scene, based on the latest data to be released, but past experiences mean it wouldn't surprise me if further trials cast doubt on its efficacy.

When treatments that work against Alzheimer's disease do appear – and I am confident that this will eventually happen – we'll all have work to do to convince the NHS that this represents a priority for funding.

There are currently 850,000 people in the UK living with dementia and, as the population gets older, that will quickly turn into 2 or 3 million.

It is definitely an exciting and positive time to be working clinically in the field and to be involved in research. However, there's so much still to do, and we have to ensure that the advances being made are not reversed because of shortage of resources or because older people aren't seen as a priority for investment.

Money is beginning to flow into research now, but more is needed to expand and develop clinical services. We can't work magic if we're not given the staff and the resources to build and to keep things going.

Making research everybody’s business

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“We have to ensure that the advances being made are not reversed because older people aren’t seen as a priority for investment”

– Rob Howard
Rehab’s pathway to recovery faces ‘virtual’ threat

Helen Killaspy, professor of rehabilitation psychiatry at UCL and consultant psychiatrist for the Islington community rehabilitation team, reveals her hopes and fears for services to help people with complex psychosis.

Nobody would dispute that we are a million miles away from the times when people with complex needs were sent off to a bed in the private sector – on average, 40km from their home, but sometimes hundreds of kilometres away. The loss of contact makes it very difficult to work with them in a graduated way and facilitate their discharge back into the local supported accommodation pathway, so they tend to get stuck in these “out of area” hospitals.

My research focuses on people with complex psychosis – those with illnesses such as schizophrenia and who often have additional problems that have complicated their recovery. During the 15 years I’ve been working as an NHS consultant, this group has become increasingly marginalised from policy and alienated from appropriate local service provision. A growing focus on more specialist sub-groups – such as people with a particular diagnosis or at a certain stage of recovery – has been the detritus of people with complex psychosis, who tend to need long-term services. Understandably, there has been a drive to minimise the time people spend in more expensive services, so those who have long-term and very high support needs tend to be the victims of policy that likes to focus on people who get better.

The decisions about service investment plans for the more complex group get passed between local authorities and NHS clinical commissioning groups. When you’re talking about very expensive people, that argument gets a lot tenser.

The cuts to NHS rehabilitation services across the country mean a lot of trusts don’t have a rehabilitation service at all – yet people with very complex problems are, of course, still being admitted to hospital when they break down in the community. The latest Care Quality Commission (CQC) data suggests that more than half of the rehabilitation beds in the country are provided in the private sector – where there may also be a financial disincentive to discharge people.

The providers of the first components of this system are the NHS local authorities (which commission the third sector) provide the latter. Our research has involved developing tools to assess the quality of these services, to understand the aspects of treatment and care that are most effective for people at the different stages of their recovery.

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This has been allowed to happen despite evidence from our research and other researchers that when you have a local whole system rehabilitation pathway, you can enable the vast majority of people with complex needs to achieve and sustain community discharge. The rehabilitation world is busy campaigning and using the evidence to do whatever we can to draw attention to the need for local reinvestment in these services. I’m the CQC’s national adviser for mental health rehabilitation and was brought in to some meetings with the former health secretary, Jeremy Hunt, on this topic. He was keen to get money back into local rehabilitation and supported this – yet people with very complex problems are, of course, still being admitted to hospital when they break down in the community. The latest Care Quality Commission (CQC) data suggests that more than half of the rehabilitation beds in the country are provided in the private sector – where there may also be a financial disincentive to discharge people.

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Resources needed to keep social revolution on track

Claudia Estcourt, clinical professor of sexual health and HIV at Glasgow Caledonian University and CNWL NHS trust, and honorary professor at UCL, on how lack of funding undermines improvements in attitudes

There have undoubtedly been huge changes in social and sexual attitudes and behaviours, which we are able to track very clearly thanks to documented evidence in the once-a-decade National Survey of Sexual Attitudes and Lifestyles led by UCL.

In the 1960s, it was well recognised that the advent of the oral contraceptive pill changed people’s behaviour by making it possible to have sex without fear of pregnancy. Subsequent to that, there have been changes in societal attitudes to homosexuality, both male to male and female to female, most evident in the 1967 decriminalisation of homosexuality between men over the age of 21 in the UK.

We are now accumulating evidence on the next wave of change – how technologies have altered our sexual and social networks and behaviours.

The change I am expecting to see is how social media has pushed us in a slightly different direction, from an overall liberalisation of attitudes about sex to a very quick and easy availability of partners through “dating” apps.

The major shifts within sexual healthcare can be split up into attitudinal, behavioural, technological and pathogens (that is, the bugs).

In the 1980s, the threat of HIV made people take fewer risks because it was the way to prevent transmission of a fatal infection. Now we are accruing data on the use of pre-exposure prophylaxis (PrEP), a pill taken before sex by people at high risk of HIV. In my clinic in Scotland, we provide PrEP as a routine service and not just as part of a trial. My feeling is that we are going to observe greater risk behaviours in our community of men who have sex with men, who quite rightly know that they are protected from HIV and perhaps aren’t so concerned about the consequences of treatable STIs.

Although it is a huge positive that we’re protecting these men against HIV, we are yet to solve what we think will be an issue with an increase in associated bacterial STIs.

The vaccine for the human papilloma virus (HPV), an infection passed between people through skin-to-skin contact, is a huge success story.

Initially, it was introduced in 2008 in England only for girls from the age of 12 (with a catch-up programme up to the age of 18) because it was felt that it would provide enough protection for boys too – as a result of so-called herd immunity.

Last year, it was brought in for men who have sex with men, because they are at high risk of anal cancer associated with HPV, and we are absolutely delighted that it has recently been agreed to implement routine HPV for all boys aged 11-12, starting next year. This is very good news, but it does place more pressure on services.

At the forefront of our concerns, though, is the challenge we need to be planning for immediately: antimicrobial resistance and potentially untreatable pathogens.

Some STIs are easily transmitted, so what could be a relatively contained outbreak could have a significant public health impact if we have infections that are extremely difficult to treat.

The press has recently heralded what they refer to as a new STI – Mycoplasma genitalium, commonly known as Mgen – but we have known about it for a long time. It shows a high degree of resistance or reduced susceptibility to commonly-used antibiotics.

Sexual health in terms of STIs services and public health, has been funded by local government, rather than the NHS, since 2012, but demand has now far exceeded capacity – as flagged by the Local Government Association’s recent plea to central government for more resources.

Across London, budget cuts have meant a 30% reduction in funding available for services, yet we know from data from Public Health England that attendances at services have increased by about 13%. We are very aware that there is a lot of unmet need, with clinics having to turn people away.

Continued on next page
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mostly felt in London, it is also happening in other areas of the UK. If a person cannot get into services, they cannot access the care they need or get infections diagnosed, and so transmission increases within the community. In sexual health services, we’ve always been pretty good at embracing good pressure, frequently having to find ways to deliver services more effectively and more leanly to cater for the demand. The advent of eHealth and non-invasive diagnostics is opening up possibilities for patients to self-manage their care, which is very much along the lines of freeing up space for face-to-face consultations with people who might be more in need because of their social or cultural complexities. However, research funding for this sort of large-scale, robust eHealth evaluation needs to be made available. These are extremely challenging times, with sexual health services so over capacity that it is difficult even to see the people who do identify the need to access them. It is becoming hard to resource efforts to attract people we think we could do a lot for in terms of prevention and reduction of unwanted pregnancies, and who may perceive barriers to getting our service. That’s something about which we feel tremendously uncomfortable. The road from childhood to adulthood has only recently emerged as a priority for research with anxieties and stresses — but perhaps never more so than for today’s generation. Seventy-five per cent of mental health conditions start before the age of 18, with consequences that can be lifelong, according to research charity MQ’s manifesto for young people’s mental health. A report published this August by the Children’s Society, led by UCL – revealed that 22 per cent of girls and nearly one in 10 boys were self-harming. And a report last year in the British Medical Journal said that self-harm reported to GPs among teenage girls under 17 in the UK increased by 88% over just three years – three times more than among boys – and that those who self-harm are at much greater risk of suicide. There is concern that the pressures of contemporary culture and modern technology – such as smartphones, Instagram, Facebook – could be exacerbating the problem in ways that would have seemed inconceivable at the time the NHS was founded. Research has helped us to improve our recognition of mental health issues in young people, but there is still so much more that needs to be done, according to Dr Eilis Kennedy, consultant child and adolescent psychiatrist and director of research and development at the Tavistock Clinic. Dr Kennedy, who is also children and young person’s mental health research champion for the NHF Clinical Research Network North Thames says “initiatives such as the MQ manifesto are helpful in highlighting the importance of these issues, and the relative lack of investment in research funding.” “This is starting to change as the importance of a lifelong perspective on mental health and the need to address issues early on in childhood and adolescence are increasingly recognised.” We don’t fully understand why so many girls are self-harming, and why there has been such an increase in recent years. “That’s why we urgently need more research to better understand the causes, and also how best to support young people, their families and the professionals working with them. Services are often struggling with the increased demand and that is not helping the situation”.

Unless there are alternatives preserved for people in these groups, there is the possibility that we could widen the health divide with clumsily-introduced eHealth. On a more optimistic level, I would hope that many more complex elements of health will be offered online – for appropriate people under appropriate circumstances – for those who are able and willing to manage elements of their own sexual health. This could provide real advantages in terms of freeing up space for face-to-face consultations with people who might be more in need because of their social or cultural complexities. However, research funding for this sort of large-scale, robust eHealth evaluation needs to be made available.

There is concern that the pressures of contemporary culture and modern technology – such as smartphones, Instagram, Facebook – could be exacerbating the problem in ways that would have seemed inconceivable at the time the NHS was founded. Research has helped us to improve our recognition of mental health issues in young people, but there is still so much more that needs to be done, according to Dr Eilis Kennedy, consultant child and adolescent psychiatrist and director of research and development at the Tavistock Clinic. Dr Kennedy, who is also children and young person’s mental health research champion for the NHF Clinical Research Network North Thames says “initiatives such as the MQ manifesto are helpful in highlighting the importance of these issues, and the relative lack of invest-ment in research funding.” “This is starting to change as the importance of a lifelong perspective on mental health and the need to address issues early on in childhood and adolescence are increasingly recognised.” We don’t fully understand why so many girls are self-harming, and why there has been such an increase in recent years. “That’s why we urgently need more research to better understand the causes, and also how best to support young people, their families and the professionals working with them. Services are often struggling with the increased demand and that is not helping the situation”.

You can diagnose many infections from a urine test or from a vulval or vaginal swab that somebody can do themselves, and people can supply their own samples for blood testing using finger-prick tests. However, the vast majority of eHealth innovation has been introduced without robust evaluation, which is the only way we can tell whether something is cost-effective and whether we’re potentially disadvantaging those who might find it most difficult to access services. My UCL team, working with colleagues in other areas of the UK, are looking at how we might deliver complex care pathways online for patients who are digitally literate, health literate and might deliver complex care pathways online for patients who are digitally literate, health literate and who feel that accessing the service in this way meets their needs. However, we have to be very careful that this isn’t seen as a complete replacement of face-to-face care, because the people we worry most about are those who don’t like accessing care online, might not have English as their first language, and might be very vulnerable.
Anne Lingford-Hughes, professor of addiction biology at Imperial College London and consultant psychiatrist at CNWL on exploring the neuroscience of addiction – and the damaging effect of cuts

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The following sessions are being hosted by Noclor and our associates. All the sessions are free and open to all staff who have an interest in research (including doctors, dentists, nurses, research assistants) and who are working in, or are associated with, our partner trusts.

For information and bookings of Noclor courses, visit www.noclor.nhs.uk to download your booking form. If there is a training subject that your research staff would benefit from that we do not currently offer, please do get in touch with us at: irina.grinkova@nhs.net

Pathways to training opportunities

- **Good Clinical Practice in Research**
  Monday, 10 December
  13.00-17.00

- **Essential Skills for Conducting Effective Clinical Research**
  Tuesday, 11 December
  9.30-17.00

- **Informed Consent in Clinical Research**
  Wednesday, 12 December
  13.00-17.00

- **Principal Investigator in Research**
  Wednesday, 12 December
  17.30-19.30

- **Setting up and Managing the Trial Master File**
  Thursday, 13 December
  9.30 – 13.30

All these courses will be held at St Pancras Conference Centre, St Pancras Hospital, 4 St Pancras Way, London, NW10PE.

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**Key Contacts**

The Noclor Research Support team is here to help you with research. So please feel free to contact our various teams.

For queries relating to Research Management and Support contact.noclor@nhs.net

Funding and Finance queries: finance.noclor@nhs.net

Looking for advice with or interested in a project in Primary Care? Contact: primarycare.noclor@nhs.net

Keen to learn more about our free training courses, or to offer content suggestions for future Noclor publicity material? Contact: irina.grinkova@nhs.net

If you would like to get in touch with our Service Director, Lynis Lewis, please contact: irina.grinkova@nhs.net

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**Power of trials creates a clear picture of health**

If anyone was ever tempted to question the power of research to improve healthcare, a quick word with Suzie Willis would soon dispel any doubts.

The photograph of Suzie, consultant occupational therapist at Central and North West London NHS Foundation, with husband Nick and dog on a 2016 holiday in the west of Ireland would not have been taken had it not been for clinical research trials.

Three years earlier Nick’s chances of surviving malignant melanoma were rated no higher than 13 per cent. But the future, so bleak back then, is now so much brighter as a result of research at the Royal Free hospital, Hampstead.

Suzie recalls that the problem began in 2010, when a mole on the back of Nick’s leg “turned nasty.” He was 52 at the time, cycled and walked everywhere, fit as a fiddle, and never had to take a day off from his work as an architectural photographer.

He was eventually referred to the Royal Free – under the care of consultant oncologist Dr David Chao – and subsequently had the mole surgically removed. However, a recurring need for surgery over the next three years eventually led to a diagnosis in 2015 that the cancer was now too deep to be operated on again.

Nick was put forward by Dr Chao for the Columbus clinical trial comparing combinations of MEK inhibitor drugs, but after getting a clear scan in January 2016, by September the cancer had come back. The game-changer for Nick came in summer 2016, when NIACE licensed the combined use of two immunotherapy drugs – a monoclonal antibody called pembrolizumab and ipilimumab, a humanised antibody that had been clinically trialled by Dr Chao – for NHS use in the treatment of melanoma.

Nick was started on the immune therapies in November and, by January 2017, a scan showed that he was clear of cancer.

Suzie, who sees a key aspect of her OT role as being to embed the culture of research – using it and participating in it – in everyday clinical practice, says: “Dr Chao is such a wonderful man, and the power of research really is incredible. It’s our future.”
Projects currently recruiting

● **SUMMIT**: Screening study using low dose CT to support the development of blood tests for early detection of lung cancer. Four London hospitals have been gifted CT scanners as part of the study, which will involve 50,000 primary care patients aged 50-77 (current smokers, previously regular smokers and people with no significant history of smoking) across north and east London. More information: noclor.norththamescrn@nhs.net

● **CHIPS+**: A cohort study on optimising the health of young people with HIV in their transition from paediatric to adult care, focusing on participants who acquired HIV perinatally or in early life (PHIV). The aim is to study 1,500 people aged 15 years and above, the large majority of whom will have been followed up as part of the national Collaborative HIV Paediatric Study (CHIPS). More information: mrcctu.chipsplus@ucl.ac.uk